

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05531
Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>"Piney Neck", Rock Hall, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blue STAR HIGHWAY RT. 71</u>		d. STREET ADDRESS <u>14X2.2</u>	
3. NAME OF DECEASED (Type or print) <u>William Howard Beck</u>		4. DATE OF DEATH <u>May 4 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN 25 1931</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISHING</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERBERT E Beck</u>		14. MOTHER'S MAIDEN NAME <u>IRENE Rollison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. HERBERT Beck</u>		Address <u>Rock Hall, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>auto accident Fractured skull</u> 825X DUE TO <u>broken neck + fractured right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Man off roadway</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT 71</u>		20f. (City or town) <u>Rock Hall</u> (County) <u>99</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/6-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 7 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>		22d. LOCATION (City/ town, or county) (State) <u>Rock Hall Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James V. Butler</u>		ADDRESS <u>Barton Bn. Centerville, Maryland</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Elice Clemetson</u>	
DATE <u>5/6/57</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH HOME		SEX MALE	
AGE 45		RACE WHITE	
OCCUPATION DRIVER		MARITAL STATUS SINGLE	
DATE OF DEATH MAY 20 1957		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH MAY 25 1912	
NAME OF DECEASED JOHN J. SMITH		SOCIAL SECURITY NUMBER 123-45-6789	
NAME OF NEXT OF KIN MRS. J. SMITH		ADDRESS 123 MAIN ST. NEW YORK	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF EXAMINER DR. J. SMITH		SIGNATURE OF WITNESS MRS. J. SMITH	

BUREAU V. 21

MAY 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05542

CERTIFICATE OF DEATH

Reg. Dist. No. 05582

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admision) o. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>P.</u> Last <u>BOOKER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 25, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOSEPH W. PRICE</u>		14. MOTHER'S MAIDEN NAME <u>LUCY HARRINGTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-6365B</u>	
17. INFORMANT <u>J. NEVITT BOOKER</u>		Address <u>SUDLERSVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Deletations</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>General Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Radius Voletra 1954</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>W</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>W</u> 19	20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 19, 1947</u> to <u>May 6, 1957</u> , that I last saw the deceased alive on <u>May 6, 1957</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Sudlersville, Md 21789</u> DATE SIGNED <u>5/9/57</u>	
PHYSICIAN'S NAME (Type) <u>Sudlersville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUDLERSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward M. Bellows, Millington, Md</u>		24a. REC'D BY REGISTRAR <u>Edgar L. Lane</u> DATE <u>5/13/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Block, Book, No.

PLACE FOR SIGNATURE OF DECEASED (If deceased is a child, the signature of the parent or guardian should be given)		PLACE FOR SIGNATURE OF WITNESSES (If deceased is a child, the signature of the parent or guardian should be given)	
NAME OF DECEASED (Print name in full)		SEX (Male or Female)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If deceased is a child, the occupation of the parent or guardian should be given)		CAUSE OF DEATH (If deceased is a child, the cause of death should be given)	
DATE OF DEATH (Month, day, year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, minute)		NAME OF PHYSICIAN (If deceased is a child, the name of the physician should be given)	
NAME OF FUNERAL HOME (If deceased is a child, the name of the funeral home should be given)		NAME OF BURIAL PLACE (If deceased is a child, the name of the burial place should be given)	
NAME OF NEXT OF KIN (If deceased is a child, the name of the next of kin should be given)		NAME OF MINISTER (If deceased is a child, the name of the minister should be given)	
NAME OF CLERGYMAN (If deceased is a child, the name of the clergyman should be given)		NAME OF CHURCH (If deceased is a child, the name of the church should be given)	
NAME OF CEMETERY (If deceased is a child, the name of the cemetery should be given)		NAME OF GRAVE (If deceased is a child, the name of the grave should be given)	
NAME OF INTERVIEWER (If deceased is a child, the name of the interviewer should be given)		NAME OF REPORTER (If deceased is a child, the name of the reporter should be given)	
NAME OF REGISTRAR (If deceased is a child, the name of the registrar should be given)		NAME OF CLERK (If deceased is a child, the name of the clerk should be given)	

BUREAU V. 1

MAY 13 1957

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE COUNTY CLERK OF THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH, WHO IS TO BE RESPONSIBLE FOR THE DECEASED'S BURIAL OR CREMATION. THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, IS NOT RESPONSIBLE FOR THE DECEASED'S BURIAL OR CREMATION.

05543

CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POND TOWN, RURAL CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Chestertown-rural (Pondtown)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS</u> <u>CLARK</u>		4. DATE OF DEATH Month Day Year <u>MAY</u> <u>21</u> <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWN FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>EDWARD CLARK</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EMMA REESE, R.D. 1 Chestertown md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Genl Arterial Sclerosis</u> DUE TO (c) <u>Genl Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Genl Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 16, 1927</u> , to <u>Aug 21, 1957</u> , that I last saw the deceased alive on <u>Aug 18, 1937</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. C. Whitehead</u> M.D.		DATE SIGNED <u>5/24/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>5/25/57</u>	<u>EWINGTOWN CEM.</u>	<u>CHURCH HILL (RURAL) MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington Md</u>		24a. REC'D BY REGISTRAR <u>May 28 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar Lenz</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

James Thompson
Grand Central Station
James Thompson
Grand Central Station

BUREAU V. 1

RECEIVED

MAY 28 1957

James Thompson
Grand Central Station
James Thompson
Grand Central Station

05544

CERTIFICATE OF DEATH

Reg. Dist. No.

257

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u> X1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>G.</u> Middle <u>JACKSON</u> Last		4. DATE OF DEATH <u>MAY</u> Month <u>10</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1880</u>
9. AGE (In years, last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMOWN</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ann Cahall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Janie W. Jackson</u> Address <u>Barclay Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Constitutional Hypertension</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>As the cause</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>W</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>W</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 10, 1957</u> , to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>July 10, 1957</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. H. Upsteele</u> M.D.		DATE SIGNED <u>July 5/13/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, Q.A. Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>Edgar L. Lanier</u>	
ADDRESS <u>Nellington Md</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lanier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 JUN 3 1957
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05546

CERTIFICATE OF DEATH

05536

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hammond St.</u>				d. STREET ADDRESS <u>Hammond</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Vansant</u>				14. MOTHER'S MAIDEN NAME <u>Etinor Boots</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. David Middleton Sr. - Centreville</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Arteriosclerotic C-V Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Sev. yrs.</u> <u>Sev. yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>57</u> , and that death occurred at <u>9:10</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>5/17/57</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22. BURIAL, CREMATION, REMOVAL (Specify) <u>MAY 20</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR DATE <u>5/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Armstrong</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05547

CERTIFICATE OF DEATH

Reg. Dist. No.

05537
234

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O'Donnell</u> Last <u>O'Donnell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Horney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Ethel O'Donnell</u> Address <u>Grasonville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic C-U Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>? yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332 X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May</u> , 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Queenstown Md</u> DATE SIGNED <u>5/9/57</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake</u>	22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Barton & Barton Son</u> ADDRESS <u>Chesapeake Maryland</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>5/9/57</u>	24b. REGISTRAR'S SIGNATURE <u>Allen M. Aldridge</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>May 10 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARITAL STATUS <i>Married</i>	
OCCUPATION <i>Teacher</i>		PLACE OF BIRTH <i>Maryland</i>	
EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF BURIAL <i>May 12 1957</i>		PLACE OF BURIAL <i>St. John's Church</i>	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYPERSON	
SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	

BUREAU V. B.
MAY 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05538

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Wyoming</u> b. COUNTY <u>Del</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bullettsville, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>✓</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>46X-3</u>			
3. NAME OF DECEASED (Type or print) <u>Lindford Penniwice</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/1905</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Body man</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Elias Penniwice</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Penniwice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mrs. Gertrude Penniwice</u> Address <u>Aspen, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> <u>823X</u> DUE TO <u>Internal Injuries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal Injuries</u> DUE TO (c) <u>Internal Injuries</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck a fork with his Car</u>					
20c. TIME OF INJURY Hour <u>5</u> a. m. <u>17</u> p. m. 19 <u>57</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>	20f. (City or town) <u>Seaside, Del.</u>	(County) <u>Del.</u>	(State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. F. McTherson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. F. McTherson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ZION</u>	22d. LOCATION (City, town, or county) <u>Wilmington</u>	(State) <u>Del</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>			ADDRESS <u>Church Hill</u>	24a. REC'D BY REGISTRAR <u>May 17</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED
MAY 20 1957
BUREAU V. 2

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05539

05549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingstown (Chestertown)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingstown (near Chestertown)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		d. STREET ADDRESS RFD Chestertown, Md.	
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Stouffer		4. DATE OF DEATH Month May Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1878
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner of truck		10b. KIND OF BUSINESS OR INDUSTRY Hauling	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Stouffer		14. MOTHER'S MAIDEN NAME Catherine Blackiston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-32-9502	
17. INFORMANT Mrs. Cora Stouffer		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 434.1 DUE TO Old rheumatic fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) As a child DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1 , 19 53 , to May 7 , 19 57 , that I last saw the deceased alive on May 6 , 19 57 , and that death occurred at 11:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 5-8-57			
ACTUAL SIGNATURE A. C. Dick M.D.		DATE SIGNED 5-8-57	
PHYSICIAN'S NAME (Type) A. C. Dick		Chestertown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wallis Wells		24a. REC'D BY REGISTRAR MAY 10 1957	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Clara Barnes	

U.S. DEPARTMENT OF HEALTH—BALTIMORE 18

MAY 10 1957

RECEIVED

05550

CERTIFICATE OF DEATH

Reg. Dist. No.

05540-1

1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. LENGTH OF STAY IN lb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LENA C. TRUITT</u>		4. DATE OF DEATH <u>MAY 23 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WALTER CLAYTON</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SHELTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. BERTHA HIGMAN</u>		Address <u>MD. SUDLERSVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Central Nervous System</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of art. Popliteal Artery</u> DUE TO (c) <u>General Arterial Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>60 days</u> <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Tw</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 23, 1957</u> to <u>May 23, 1957</u> that I last saw the deceased alive on <u>May 23, 1957</u> and that death occurred on <u>May 23, 1957</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. H. H. H. H. H.</u>		DATE SIGNED <u>5/24/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SUDLERSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>MAY 28 1957</u>	
ADDRESS <u>Millington Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar Long</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The form is mostly blank with some faint markings.

General Hospital
Thompson St. Hospital
General Hospital
General Hospital

RECEIVED
MAY 28 1957
BUREAU V. B.
General Hospital
Thompson St. Hospital
General Hospital

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05551

CERTIFICATE OF DEATH

05541

Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 Stevensville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>Walter</u> Middle <u>White</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29-1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farm owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thos. Walter Kirby White</u>				14. MOTHER'S MAIDEN NAME <u>Julia Winchester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>J. Walter White Jr.</u>				Address <u>Stevensville Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>				ADDRESS (Street, city or town, state) <u>Quacustus Town, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u>				DATE SIGNED <u>5/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 29</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Sane</u>				ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>June 1-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth Koster</u>			

RECEIVED

JUN 4 1957

BUREAU V. 3

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. MANNER OF DEATH		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. EDUCATION	
11. RELIGION		12. MARITAL STATUS	
13. SOCIAL SECURITY NUMBER		14. DATE OF BIRTH	
15. PLACE OF BIRTH		16. DATE OF ENTRY INTO COUNTRY	
17. NAME OF NEXT OF KIN		18. ADDRESS OF NEXT OF KIN	
19. NAME OF PHYSICIAN		20. NAME OF HOSPITAL	
21. NAME OF FUNERAL HOME		22. NAME OF BURIAL PLACE	
23. NAME OF CEMETERY		24. NAME OF INTERMENT	
25. NAME OF CREMATOR		26. NAME OF CREMATION	
27. NAME OF INCINERATOR		28. NAME OF INCINERATION	
29. NAME OF BURIAL		30. NAME OF BURIAL	
31. NAME OF BURIAL		32. NAME OF BURIAL	
33. NAME OF BURIAL		34. NAME OF BURIAL	
35. NAME OF BURIAL		36. NAME OF BURIAL	
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65. NAME OF BURIAL		66. NAME OF BURIAL	
67. NAME OF BURIAL		68. NAME OF BURIAL	
69. NAME OF BURIAL		70. NAME OF BURIAL	
71. NAME OF BURIAL		72. NAME OF BURIAL	
73. NAME OF BURIAL		74. NAME OF BURIAL	
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87. NAME OF BURIAL		88. NAME OF BURIAL	
89. NAME OF BURIAL		90. NAME OF BURIAL	
91. NAME OF BURIAL		92. NAME OF BURIAL	
93. NAME OF BURIAL		94. NAME OF BURIAL	
95. NAME OF BURIAL		96. NAME OF BURIAL	
97. NAME OF BURIAL		98. NAME OF BURIAL	
99. NAME OF BURIAL		100. NAME OF BURIAL	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05542

05552

CERTIFICATE OF DEATH

Reg. Dist. No. 257

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>				c. LENGTH OF STAY IN 1b <u>4 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>20x2.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Wilson</u> Middle <u>Wilson</u> Last				4. DATE OF DEATH <u>May</u> Month <u>11</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Fred Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Carroll Wilson</u> Address <u>Queenstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic - Hypertensive</u> DUE TO (c) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sev. Yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>57</u> , and that death occurred at <u>12:45</u> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>				DATE SIGNED <u>5/11/57</u>			
ACTUAL SIGNATURE <u>Irvin E. Hoyt</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Irvin E. Hoyt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/14/57</u>		22b. DATE THEREOF <u>5/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gouldtown</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville rt. 2, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR <u>5/21/57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Kelen Aldridge</u>	

BUREAU V. 3

MAY 20 1957

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